Utah Department of Health

Promote ☐ Prevent ☐ Protect

Covered At Work

Application Form

Please Mail This Form to: Covered At Work, P.O. Box 16520, Salt Lake City, UT 84116

The information on this form will help the Utah Department of Health to decide if you fit the guidelines for this program.

1. Personal Information

Name: _____
First Middle Last

Address: _____
Street Apt.# City State ZIP

Home Phone: _____ Daytime Phone: _____

2. Household Information - Beginning with yourself, list all the people who live in your home.

* You do not need to list the Social Security Number or Citizenship for any household member not applying for coverage.

Name	Relationship	Social Security Number*	Date of Birth	Age	Sex	Race / Ethnicity (opt)*	Marital Status

*Race/Ethnicity codes: B-Black, W-White, I-American Indian/Alaskan Native, A-Asian, P-Pacific Islander, H - Hispanic/Latino , O-Other

The adults applying for PCN are: ❑ U.S. Citizens ❑ Legal Aliens ❑ Other

If legal aliens, please provide alien registration numbers: _____

3. Income Information - Include income from alimony, child support, unemployment, Social Security, etc.

Name of Person Receiving Money	Employer or Income Source	Gross Amount	How Often Paid	# Hours Per Pay Period

4. Insurance Information

A. Do you or your spouse have insurance? ‘ No ‘ Yes

If you answered yes:

Name of Insurance Company: _____ Phone #: _____

Address of Insurance Company: _____ Group #: _____

Policyholder Name: _____ Policy #: _____ Start Date: _____

If insurance is through an employer, list employer name and phone #: _____

Premium: $_____ Date Due: _____ How Often? _____

Names of Persons Covered: _____

B. Are you or your spouse offered insurance through an employer which you have not purchased? ‘ No ‘ Yes

If you answered yes:

Employer Name and Phone #: _____

Employee Name: _____

Type of Coverage: _____

Cost for Employee: _____ Cost for Spouse: _____

C. Have you or your spouse had insurance that has ended in the past 6 months? ‘ No ‘ Yes

If you answered yes:

Why did it end? _____

When did it end? _____

Name of Insurance Company: _____ Phone #: _____

Policyholder Name: _____ Policy #: _____

D. Have you or your spouse been injured in an accident or assault? ‘ No ‘ Yes

If you answered yes, explain: _____

E. Are you or your spouse a full-time student? ‘ No ‘ Yes

If you answered yes:

Who is the student? _____

What is the name of the school? _____

F. Have you or your spouse ever served in the military? ‘ No ‘ Yes

If you answered yes:

Who? _____ Dates of Military Service? _____

Notes:

I Understand that:

I assure that I am a U.S. citizens or alien in lawful immigration status. I also assure that if this application is requesting benefits for my spouse, that he/she is also a U.S. citizen or alien in lawful immigration status. The Utah Department of Health (UDOH) will verify alien registration numbers with the Immigration and Naturalization Service (INS). The UDOH will not report undocumented household members to INS.

My spouse (if applicable) and I will obey the medical assistance program rules. If I receive medical assistance which I am not eligible to receive, I will be responsible for repaying the medical assistance. I will allow only the people named on the medical card to use the medical card.

If the UDOH pays for my medical care, I assign to it my rights to payments from any third party and to benefits for medical services. I will give to the UDOH any money I collect from an insurance policy or from someone required to pay for my medical expenses. I authorize payment directly to the UDOH or the Office of Recovery Services and will hold harmless any party making payment to them.

I agree that the assistance I receive under any medical program is limited to that described in the Provider Manuals that the UDOH has written. I understand that the benefits I am eligible to receive may be changed without my knowledge or consent. I further agree to be responsible for any co-pays to providers at the time of medical service unless I am exempt from those co-pays.

I authorize any person or organization to release medical records or information about my health or the health of my dependents to the UDOH, Division of Health Care Financing or designee. The UDOH and the Department of Workforce Services may give health care providers information about my eligibility for medical assistance.

The State has the right to recover from my estate all money spent to pay my medical bills if I receive Medicaid at any time while I am 55 years of age or older.

I give permission for ANY INFORMATION LISTED ON THIS FORM TO BE VERIFIED. My medical benefits may be reduced, denied, or stopped because of information received. I understand that failure to report changes and any false information given on this application, or subsequently provided, may result in prosecution for fraud. I understand that I may ask for a fair hearing if I disagree with the decision made on this application.

**** *I (print name) _____, read or had read to me the statements on this page. I understand those statements. Under penalty of perjury, I swear that the answers I have given on this application are complete and correct. I am the person represented by the signature on this document.*

_____ _____

Signature of the Applicant or Representative Date

VOTER REGISTRATION INFORMATION

If you are not registered to vote where you live now, would you like to apply to register to vote here today? ❑ Yes ❑ No

If you do not check either of these boxes, we will assume you have decided not to register to vote at this time. You may fill out the application form in private. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. Choosing to register or declining to register to vote will not effect the amount of assistance that you will be provided by this agency. If you believe that someone has interfered with your right to register, your right to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with Lt. Governor, Olene S. Walker, State of Utah, 203 State Capitol Building, Salt Lake City, UT 84114.

Action Taken

This Section To Be Completed By The Worker Worker Name:

❑ PCN Info ❑ Rights & Responsibilites / 476 ❑ SAVE

❑ Estate Recovery (55+) ❑ Medicaid For Those With Disabilities

Application Status ❑ Approved ❑ Denied - Reason_____ Date:

Comments: